Breast History

Patient Name: _____

1. Race

- o African American
- o Asian/Pacific Islander
- o Caucasian
- o Hispanic/Latino
- o Other/Prefer not to answer

2. Do you drink alcohol?

- o Yes
- o No

3. How old were you when first started your period?

Age _____

4. How old were you when you had your first child?

Age _____

- o I've never had children

5. How many times have you been pregnant? _____

6. Number of viable (living) offspring at birth _____

7. Number of abortions (including spontaneous and induced) _____

8. When was your last menstrual period?

Date ___/____/_____

Age at menopause _____

9. Which type of birth control are you currently using?

Name _____

- o I am not currently on birth control medication

10. Have you had any hormone replacement therapy within the last 5 years?

- o Yes
- o No

11. Have you ever been exposed to any form of radiation?

- o Yes
- o No

12. Have you have breast problems before?

- o Yes
- o No

13. What were your previous mammogram results?

- o Normal
- o Abnormal

14. Have you ever been diagnosed with *breast cancer*?

- o Yes
- o No

15. Do you have any family history of *breast* or *ovarian* cancer? If so, what relative and which type?

Breast or Ovarian	Relationship